1059 Main Street
P.O. Box 30035
Worcester, MA 01603

Jeremiah's Inn
Helping people through our social model recovery program and nutrition center.

Phone: (508) 755-6403
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CONSENT TO DISCLOSE INFORMATION FORM

Name: _____ **DOB:** _____

I, the undersigned, hereby consent to the release of information specified below:

PURPOSE OF DISCLOSURE

Any other use of the information is forbidden

Name of Agency: **Contact Name:**

Street Address: **Fax:**

City: **State:** **Zip:** **Phone:**

THE INFORMATION TO BE DISCLOSED:

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychosocial Evaluation
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan or Summary
- ☐ Current Treatment Update
- ☐ Medication Management Information
- ☐ Residency/Participation in Treatment
- ☐ Nursing/Medical Information
- ☐ Toxicological Reports/Drug Screens
- ☐ Educational Information
- ☐ Discharge/Transfer Summary
- ☐ Continuing Care Plan
- ☐ Progress in Treatment
- ☐ Demographic Information
- ☐ HIV/Aids Diagnosis, AntibTreatm
- ☐ Other _____

Dates of involvement with your agency: _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If the purpose is other than as stated above, please specify:

_____

This information can be disclosed in writing ☐ and verbally ☐. Please note that under certain circumstances, some information disclosed verbally to treatment providers and government agencies may lose some protections under 42. CFR and will only be protected under the less restrictive HIPAA privacy regulations. Disclosures to private citizens such as friends, relatives etc. will not be protected under 42.CFR or HIPAA.

I understand that **my records are protected under Federal regulations** governing Confidentiality of Alcohol and Drug Abuse Patients Records, **42CFR Part 2,** and cannot be disclosed without my written consent unless otherwise provided for in regulation. I also understand this consent is subject to revocation at any time except to the extent that action has already been taken in reliance on it, and will automatically expire upon discharge from Jeremiah's Inn unless an earlier date, event or condition is specifically provided below. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by **42CFR Part 2.** A general authorization for the release of medical and or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
Earlier Date, Event, Condition:
I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been provided a copy of this form.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____